Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BRECKENRIDGE SURGERY CENTER
3201 EAST GEORGE BUSH FRWY 100
RICHARDSON TX 75082

Respondent Name

ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-2242-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Correct allowable per TWDC fee guidelines for procedure 267665 is $2357.30/11760 is $123.49."

Amount in Dispute: $1,681.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 22, 2010	ASC Services for Code 26765-SG	$1,681.93	$1,681.93

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. Neither party to this dispute submitted copies of explanation of benefits for the disputed date of service. The requestor submitted a copy of a check for $962.61.

Issues

1. Did the requestor support position that additional reimbursement is due for ASC services for code 26765? Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

   On the disputed date of service the requestor billed HCPCS codes 26765-SG and 11760-SG. The requestor is not seeking dispute resolution for HCPCS code 11760-SG.

   HCPCS code 26765 is defined as "Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each."

   28 Texas Administrative Code §134.402(f) reimbursement for non-device intensive procedure for HCPCS code 26765 is:
   The Medicare ASC reimbursement rate is found in the Addendum AA ASC Covered Surgical Procedures.
   The ASC fully implemented relative payment weight for CY 2010 = 24.1337.
   This number is multiplied by the 2010 Medicare ASC conversion factor of 24.1337 X $41.873 = $1,010.55.
   The Medicare fully implemented ASC reimbursement rate is divided by 2 = $505.27 ($1010.55/2).

   This number X City Conversion Factor/CMS Wage Index for Richardson, Texas is $505.27 X 0.9853 = $497.84.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted reimbursement $505.27 + $497.84 = $1,003.11.

   Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $1,003.11 X 235% = $2,357.30.

The MAR for HCPCS code 26765-SG is $2,357.30. The respondent paid $675.37. The difference between the MAR and amount paid is $1,681.93; this amount is recommended for additional reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $1,681.93.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,681.93 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		2/9/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.